Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DEEPAK V CHAVDA MD
8251 BEDFORD EULESS ROAD SUITE 210
NORTH RICHLAND HILLS TEXAS 76180

Respondent Name

AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-04-A739-01

MFDR Date Received

July 13, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Ins. Co. used code 27487 for Consideration in payment. Dr. did not provide the service described in code 27487. Service provided is reproducing Normal cartilage. 27599 is only appropriate code for Carticel."

Amount in Dispute: $42,532.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The billing in dispute has been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies and rules, and the Texas Labor Code. Carrier has determined that $18,956.90 represents a fair and reasonable reimbursement for this service. The provider must therefore prove that the reimbursement received is not fair and reasonable. Carrier calculated the reimbursement based upon the following policies: (1) Ambulatory surgery and outpatient hospital surgery facilities in Texas at the Medicare rate + 25%."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 2, 2004	Surgery	$42,532.27	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. This request for medical fee dispute resolution was received by the Division on July 13, 2004. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on July 15, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
2. Division rule at 28 TAC §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedure for medical fee dispute resolution.

3. Division rule at 28 TAC §134.202, titled *Medical Fee Guideline*, effective August 1, 2003, sets out the reimbursement for medical treatment.
4. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
1. Texas Labor Code §413.011 requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 12, 2004
   - TX F – Fee guideline MAR reduction. CPT 27599-22 reimbursed as CPT code 27487

   Explanation of benefits dated June 8, 2004
   - TX M – No MAR
   - TX N – No documented
   - TX S – Supplemental payment
   - Note: Pd at Medicare group 9 rate plus 25% for CPT 27599. Please submit vendor invoices for payment of autologous chondrocytes

Issues

1. Did the requestor submit documentation to support fair and reasonable reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor billed CPT code 27599-22 and 27599-80, -22. The Medicare description of the procedure is "Unlisted procedure, femur or knee." The CPT code in dispute is not valued by Medicare and is therefore subject to fair and reasonable reimbursement. The healthcare provider billed $45,000.00. The insurance carrier paid $2,467.73. The requestor is seeking reimbursement of the unpaid amount of $42,532.27.
2. The disputed service is not valued by Medicare and is therefore subject to fair and reasonable reimbursement. 28 Texas Administrative Code §134.202(c)(6) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications" and "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."
3. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b) [currently Texas Labor Code §413.011(d)], until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for CPT codes 27599-22 and 27599-80,-22.
   - Documentation of the comparison of charges to other carriers was not presented for review.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.

   - In support of the requested reimbursement, the requestor submitted a payment screen with payment amounts from various insurance carriers. However, the requestor did not discuss or explain how the

payment screen support the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the payment screen are for services that are substantially similar to the services in dispute. The carriers' reimbursement methodologies are not described on the payment screen. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

6. The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended for CPT codes 27599-22 and 27599-80,-22.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 15, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.